

**Department of Health and Human Services
Health Care Financing Administration
Center for Health Plans and Providers (CHPP)
Medicare Managed Care
Operational Policy Letter #97.060
OPL97.060 [Revised]**

Date: July 17, 1998

Subject: Updating of the "Medicare Managed Care National Marketing Guide"

Issue/Question: Change to the "Guidelines for Review of Marketing Materials for National Plans; The Lead Region Concept"

Resolution/Answer: This document is a revision to information contained in OPL 97.060, dated November 14, 1997, entitled: "Chapter XI; Guidelines for Review of National Marketing Materials" (5 pages)

Note: The circumstance precipitating this revision is that the lead Regional Office (RO) is now solely responsible for the approval of national marketing materials. Local RO's (as defined in the OPL) will no longer play a role in approval of national materials.

This OPL is the second update to the Medicare Managed Care National Marketing Guide initially issued on November 14, 1997.

Contact: HCFA Regional Office Managed Care Staff

cc: Regional Office Managed Care Staff
Center for Beneficiary Services

Chapter XI
Guidelines for Review of Marketing Materials for National Plans

Note: All changes appearing in the OPL are underlined and appear in "bold" type. Several items have been deleted in their entirety. The original OPL pages for this section should be discarded to avoid confusion.

I. Introduction

These guidelines, effective April 8, 1998, are to be used by HCFA national plan teams and national plans that prepare marketing materials for use in more than one region. The guidelines apply both to marketing materials submitted with new applications as well as post contract marketing efforts.

The purposes of these guidelines are:

- to streamline the marketing process for national plans;
- to avoid unnecessary repetition of document submission and review;
- to decrease the amount of time currently being spent on marketing material review.

II. Definitions

lead RO	<u>HCFA Regional Office (RO) with authority to approve plan's national marketing material</u>
local RO	HCFA RO with a contracted plan in its region
national plan team	staff from each HCFA RO where a plan has a Medicare contract
local plan	contracted plan within a HCFA region
national plan material	material identified by a national plan for use in more than one HCFA region
local material	material specific to a local plan
PCT	Product Consistency Team--comprised of RO and CHPP staff with responsibility to assure consistency in the application of the national marketing guidelines
PPPPG	Plan & Provider Purchasing Policy Group within the Center for Health Plans & Providers (CHPP) responsible for making policy determinations.

III. Determining The Lead Region

Generally, the RO where the plan's corporate office is located will serve as the lead RO. In some situations, a lead RO may not be the one in which the plan's corporate office is located. For example:

- the plan's corporate headquarters is in a region with no Medicare contracts.
- the national plan team designates another lead RO.
- the corporate office location changes.

Authority for determination of lead RO assignments resides with RO officials representing the geographic locations of the national plan headquarters and contract sites. When necessary, appropriate RO consortia administrators will assist in lead RO determinations.

IV. Responsibilities

A. Health Plan

- assures materials submitted are consistent with the requirements in the Medicare [*Managed Care National Marketing Guide*](#) and the *HMO/CMP Manual*.
- **submits for approval proposed copies of its national marketing materials to the lead RO with a dated cover letter which identifies the material as national. (note: all submitted materials, both national and local, must be identified with a sequential identification code. The identifying system will be determined by the RO "national plan team").**
- submits for approval proposed copies of local marketing materials to the local RO with a dated cover letter. This material will be reviewed and approved by the local RO for local use only.
- **identifies previously approved local material that the plan now wants to use nationally and submits it to the lead RO for approval. Such materials must be accompanied by the local RO's original approval letter/documentation.**
- distributes final copies of its national marketing materials, within a time frame to be determined by its national plan team (10 days after HCFA approval is recommended), to the lead **and local ROs** with a dated cover letter which identifies the recipients. **(Note: Although the local ROs no longer play a part in approval of the national marketing piece, they should be send a finalcopy of the approved material for their records).**

B. Lead RO

- notifies the local ROs of the approval dates for national materials.
- **refers policy issues which require additional development or clarification to the appropriate Central Office component.**
- requests assistance from the PCT, PPPPG or the RO HPPA Managers as necessary.
- determines Use and File status for national plan material.
- (OPTION: each lead RO and the associated national plan team ROs may request the health plan to include at the bottom of each page of marketing material an identification/approval code (e.g., HCFA**MM/YY, in which the ** represents the number of the lead RO and the MM/YY is the month and year the piece was approved. This would allow the plan to submit only

those pages that have changes in the annual review of such items as the EOC , Member handbook, etc.).

C. Local RO

- approves marketing materials which are applicable to the local plan(s) only. (approval letters will state that material is approved for local use only.)
- determines Use and File status for local material.

D. Product Consistency Team

- meets periodically to resolve issues involving inconsistencies in the interpretation, application and approval of marketing materials.
- requests written marketing policy clarifications and determinations from PPPPG.
- drafts written updates for the [Medicare Managed Care National Marketing Guide](#) and distributes them nationally to all plans and ROs.

E. Plan & Provider Purchasing Policy Group

- resolves policy questions and distributes policy determinations to all regions.
- assures that the [Medicare Managed Care National Marketing Guide](#) and the *HMO/CMP Manual* are updated to reflect changes in law, regulations and policy.

LEAD REGIONAL OFFICE ASSIGNMENTS OF MULTI-STATE, "CHAIN" CONTRACTS

(November 14, 1997)

Region	Plan Name
1	Cigna
2	HIP, NYL-Care, Prudential, Oxford
3	Aetna/USHealthCare
4	Humana
5	United HealthCare - MN

6	-
7	Coventry, Mutual of Omaha
8	-
9	FHP/Pacificare, Kaiser, Maxicare, QualMed/HSI/Foundation, Sierra Health
10	-

Marketing Guide Operations / Policy Interpretation Update

November 14, 1997

1. The marketing guide effective / implementation date is November 17, 1997.
2. Stockpiles of existing printed marketing materials which contain information contradictory to information contained in the National Marketing Guide (implemented November 17, 1997) may be used by the health plan until December 31, 1997, so long as an addendum page indicating the correct information is included with the printed document. Existing materials that do not conflict with the marketing guide may, of course, be used without concern to this limitation.
3. The same extension granted for printed materials in item number one above is granted for all other media vehicle advertisements (e.g., TV, radio, films, etc.). For example, a plan using a pre-11/17 (guide instructions) HCFA approved TV ad which does not identify actors appearing in the ad has two choices effective 11/17/97:
 1. amend the ad to acknowledge the use of actors (visual or audio means are acceptable), or
 2. cease using the ad.
4. A health plan that has, prior to November 17, 1997, made a financial commitment (i.e., deposit or full payment for facilities, entertainment, food, etc.) for a community/member social function may use the \$10 per person limit regardless of the "street value" of items associated with the social function. Example: A concert hall is rented for a concert program. The plan is able to acquire the entire hall, refreshments, entertainment, etc. for a total of under \$10 per person attending the event. Seats in the concert hall usually sell for \$15 to \$55. This would violate the new "street value" guide standards for nominal value. The plan must provide proof that the financial commitment was made prior to November 17, 1997.
5. The marketing guide IS NOT an all inclusive, static document. The guide is a "snapshot" of HCFA approved marketing practices, policies and model

beneficiary notification materials. The content of the guide will change to reflect new policy and operational requirements as they appear on the scene. The guide cannot be used by the plans to justify something new they wish to do simply because it is not prohibited in the guide -- i.e., "show me where in the guide it says we can't do this." Neither can the guide be used by HCFA to ignore change and progress by saying to the plans, "what you want to do is not possible because it is not approved/present in the guide." There is the ongoing HCFA policy process (Plan & Provider Purchasing Policy Group) that enables changes to occur. The guide will be updated to reflect new policy when it is announced by HCFA.

6. Please add this item to the marketing scenarios found in Chapter II (Promotional Activities) of the guide; page 9, Question and Answer number 10:

Q - Can a health plan take people to a casino or sponsor a bingo night at which the member's winnings may exceed the \$10 nominal fee?

A - No. The total value of the winnings may not exceed \$10 and the winnings cannot be in cash or an item that may be readily converted to cash.

Corrections and Clarifications to the Medicare Managed Care National Marketing Guide

Document Cover Letter Date - August 11, 1997

Document Release Date - September 8, 1997

1. ***Model Enrollment Letters*** A-1 (pages 36 - 37) and A-2 (pages 38 - 39) are deleted from the guide. The issue of retroactive enrollment and provision of services prior to enrollment is currently under review by HCFA's Center for Beneficiary Services and HCFA's Regional Offices (ROs). When policy for this area has been determined, model notification letters will be reinstated into the guide. Currently, all references to model letters A-1 and A-2, or the subject matter of the letters is deleted from the guide. During the interim period, contracting health plans and HCFA ROs should continue to use directives on this matter found in the HMO/CMP (Pub-75) Manual and HCFA Operational Policy Letters (OPLs).
2. ***Page 77, Section 5, Hospital Services:***
The first paragraph should be changed to read "Hospital Services shall be covered only when provided or arranged by a plan physician or by (Health Plan name) except for..." (the remaining content remains.)
3. ***Page 32, Beneficiary Guardian Signature Issue:***
The first paragraph refers to OPL 95.007 (revised). The content of

OPL95.007 (revised) is currently under revision. When the revision is completed, then the guide reference will be correct. One of the main provisions of the new OPL will include an item which indicates that "a person authorized under state law to act on behalf of the beneficiary" is permitted to sign Medicare health plan contract documents for the beneficiary. Until the OPL revision is available, and subsequently incorporated into the guide, plans should contact their Regional Office (RO) liaison for guidance in this matter.

4. Page 34, *Summary of Model Enrollment Letters, Checklist item number IV:*
The checklist for letter A-4, the "confirm Enrollment Effective Date", was omitted. The checklist will take the same format as the other checklists and will include the following items:
 1. notification that HCFA has confirmed eligibility for Medicare;
 2. enrollment effective date into the health plan;
 3. beneficiary receipt of plan membership health card;
 4. until plan effective date the beneficiary must use their existing medical services program;
 5. explanation of lock-in;
 6. explanation of emergency care and urgently needed services exceptions to lock-in;
 7. use of letter as proof of plan membership prior to receiving plan membership card.
5. Page 32, *Definition of EBMF:*
EBMF is the acronym for "Enrollment by Mail Form."
6. Page 14, first paragraph, final two words:
The term "commercial message" refers to the content of the material which is designed to capture the reader's attention regarding membership in the health plan. The term DOES NOT refer to the commercial membership (i.e., non Medicare/Medicaid members) of the health plan.
7. Page 14, first paragraph, last sentence:
The requirement is for all non-notice materials to have the same size font for both commercial message and foot notes. The size is left to the discretion of the plan. It can be smaller than size 12, as long as both commercial messages and footnotes are the same size.
8. Attachment 2, *"Comment Analysis Report on the Medicare Managed Care National Marketing Guide"*, "No category" (comment not included in guide), Item number 41:
There is no HCFA policy requiring health plans to include a disenrollment form in the new member information package. Disregard the answer associated with item number 41.
9. Page 25, Subject - *Sales Presentations*, "Must Use" column, bullet 3:
Use of the term "telecommunications device for the deaf" (TDD) does not imply any particular "brand name" piece of equipment. If there are state requirements regarding the use of a particular piece of equipment, then HCFA will follow the state's lead in this matter. The health plan has until January 1, 1998, to meet this guideline requirement.

10. Page 6, first paragraph, sentence beginning "Cash gifts are prohibited...": is changed to read: "Cash gifts are prohibited including charitable contributions made on behalf of people attending a marketing presentation and including gift certificates that can be readily converted to cash, regardless of the dollar amount.
11. Page 124, last paragraph, add this sentence at the end:
"If the mid-year benefit approved in the original ACR proposal was not disclosed in the annual notification letter, the usual advance notification requirements will apply."
12. Page 20, Subject - "Quality", "Can Use" column, Issue, *Use of Superlatives*: A member of the health plan may use a superlative in relating their personal experience with the plan so long as the testimonial is preceded with the phrase "in my opinion..." (e.g., "I have been with the health plan for ten years, and, in my opinion, they have given me the best care possible.") If the member does not preface the superlative statement with the "in my opinion" phrase, the member must substantiate the statement with an acceptable qualifying information source.
13. Page 2, last paragraph, last sentence ("Use of the model..."), replace with:
"The guide contains two categories of model notification letters/materials:
 1. those that are used for routine communications between the plan/beneficiary and contain content which does not change appreciably annually, (e.g., enrollment letter, disenrollment confirmation, etc.), and
 2. those that contain information which announce changes (usually on an annual basis) in the services or contractual arrangements between the beneficiary and the health plan (e.g., the Evidence of Coverage, the Member Handbook, the Summary of Benefits document, the Annual Notification Letter, etc.)

Use of model notification materials by the health plans is on a voluntary basis. Category 1 model materials may be used by the health plans without prior clearance from HCFA. A "file copy" of a category 1 model notification document used for the first time must be sent to HCFA within two weeks of the document's initial use. Any change in the content of category 1 materials results in the documents no longer being "model documents" and requires submission of the documents for HCFA "prior use" clearance. Category 2 model materials require "prior use" approval from HCFA.

14. Page 3, Item number 2, third sentence:
"Use of model documents does not require prior review and approval by HCFA." This should be changed to incorporate the information appearing in item number 13 above.
15. Page 6, first paragraph, *nominal value item*, at the end of the sentence "...retail purchase price of the item...", add the following:
"Local Medicare fee-for-service Fiscal Intermediary and/or Carrier charge

- listings can be used to determine the value of medical services, examinations, laboratory tests, etc. associated with nominal value marketing scenarios.
16. Page 21, Must Use Column, second bullet, *"TV Safe Range"*:
HCFA is working with the industry to determine an exact definition/requirement for this item. For the present, "TV Safe Range" means the visible area on a TV screen. The Part-B caveat must appear in the viewing portion of the TV screen and it must be of sufficient size to be readable.
 17. Page 92, Item number 1, first sentence, change:
"...ask for a service for payment..." to "...ask for a service or payment..."
 18. Page 24, Can't Use column, above first bullet *"Minimal copays may apply"*, insert additional new bullet:
 - "Minimal copays may vary by county"
 19. Page 24, Can Use column, sixth bullet, remove word "may" to read:
"Minimal copays vary by county."
 20. Page 28, item number 4, change to read:
"Provider groups can furnish a complete list of patient names to a health plan (subject to existing provider contract limitations.) The Provider group cannot disclose Medicare entitlement, age, or health status..." (continue paragraph.)

Page 8, Question 7, Answer, continue after end of sentence:

"The nominal value rule does not apply to this activity because it is not marketing as defined by HCFA. Recent federal legislation permits Medicare managed care entities to provide incentives to members for the provision of services that promote preventive care. The preceding three criteria items on page 8 must be present for the activity to be considered "outside" the purview of HCFA marketing review.